UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF NEW YORK	
	X
ALICE LAZARUS HABER,	•

Plaintiff.

07 CV 7060

-against-

NATIONAL RAILROAD PASSENGER CORPORATION d/b/a AMTRAK, METROPOLITAN TRANPORTATION AUTHORITY, LONG ISLAND RAILROAD COMPANY and ABM INDUSTRIES, INC.,

PLAINTIFF'S RESPONSE TO DEFENDANTS REQUEST FOR PRODUCTION OF **DOCUMENTS**

Defendants.	
	×

Plaintiff, ALICE LAZARUS HABER, by and through her attorneys, LEAV & STEINBERG, LLP, hereby responds to the Defendants First Request for Production of Documents as follows:

- 1) Plaintiff is not in possession of any adverse party statements.
- 2) Annexed hereto as Exhibit "A" are copies of plaintiff's medical records from the following providers:
 - a) Saint Vincent Catholic Medical Centers 153 West 11th Street New York, NY 10011
 - b) Manor Care Potomac 10714 Potomac Tennis Lane Potomac, MD 20854
 - c) Adventist Home Health: 12041 Bournefield Way, Suite B Silver Spring, MD 20904
 - d) Bethesda-Chevy Chase Orthopaedic Dr. Cannova 10215 Fernwood Road Bethesda, MD 20817
 - e) Zupnik, Winson and Chen, D.D.S., P.A. 8218 Wisconsin Avenue, Suite 203 Bethesda, MD 20814

- f) Dr. Gerald S. Gordon 8001 Inspection House Road Potomac, MD 20854
- g) Cohen, Goodman, Simon, Ribera and Menhinick, P.A. 5454 Wisconsin Avenue, Suite 1355 Chevy Chase, MD 20815-6921
- 3) Annexed hereto as Exhibit "B" are duly executed HIPPA compliant authorizations for the release of plaintiff's medical records from the following providers:
 - a) Saint Vincent Catholic Medical Centers 153 West 11th Street New York, NY 10011
 - b) Manor Care Potomac 10714 Potomac Tennis Lane Potomac, MD 20854
 - c) Adventist Home Health: 12041 Bournefield Way, Suite B Silver Spring, MD 20904
 - d) Bethesda-Chevy Chase Orthopaedic Dr. Cannova 10215 Fernwood Road Bethesda, MD 20817
 - e) Zupnik, Winson and Chen, D.D.S., P.A. 8218 Wisconsin Avenue, Suite 203 Bethesda, MD 20814
 - f) Dr. Gerald S. Gordon 8001 Inspection House Road Potomac, MD 20854
 - g) Cohen, Goodman, Simon, Ribera and Menhinick, P.A. 5454 Wisconsin Avenue, Suite 1355 Chevy Chase, MD 20815-6921
- 4) Plaintiff was not employed at the time of the accident and remains unemployed, therefore this demand is not applicable.
 - 5) Please refer to response 4 above.
 - 6) Please refer to response 4 above.

7) Annexed hereto as Exhibit "C" are copies of photographs, in plaintiff's possession, depicting the location of the accident.

Plaintiff reserves the right to supplement and/or amend the information provided above until the time of trial.

Dated: New York, New York October 30, 2007

Yours, etc.,

LEAV & STEINBERG, LLP

By: DANIEL T. LEAV (DTL 5145)

Attorneys for Plaintiff 120 Broadway, 18th Floor New York, New York 10271

(212) 766-5222

TO:

LANDMAN CORSI BALLAINE & FORD P.C.

By: Ronald E. Joseph
Attorneys for Defendants
NATIONAL RAILROAD PASSENGER
CORPORATION d/b/a AMTRAK, METROPOLITAN
TRANSPORTATION AUTHORITY and LONG ISLAND
RAILROAD COMPANY
120 Broadway, 27th Floor
New York, New York 10271
(212) 238-4800

CERTIFICATE OF SERVICE

I certify that under penalty of perjury pursuant to 28 U.S.C. Section 1746 that on November 1, 2007, I caused to be served upon the following, by First Class United States Mail, postage prepaid, a true copy of the attached Plaintiffs' Automatic Disclosure by depositing same in a postage-paid envelope in a U.S. Postal Box within New York addressed to:

COUNSEL FOR DEFENDANT

LANDMAN CORSI BALLAINE & FORD P.C.

By: Ronald E. Joseph 120 Broadway, 27th Floor New York, New York 10271

Dated: New York, New York

November 1, 2007

BANKEL T. LEAV (DTL 5145)

EXHIBIT "B"



UTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

	Date of Birth	Social Security Number
Patient Name Alice LAZARUS HABER	11-30-33	219-32-9195
	1-11 - MD 2	-052
5800 Nichold & LANE, Ros		leased as set forth on this form:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
- 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL

CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN TIEM 9 (b).				
CARE WITH ANYONE OTHER THAN THE ATTORNEY	information: Chery < hA se, MD sin Ave, Suite 1355, 20815 a this information will be sent:			
7_Name and address of health provider or entity to release this	miormation: 1.15 5 20815			
(-000MAD. P.A. 5454 WISCO	15.1 AV C/30.16/333/200.3			
8. Name and address of person(s) or category of person to whom	a this information will be sent.			
VANJOAN, CORSUIDAINIA CORSU				
9(a). Specific information to be released:				
Medical Record from (insert date)	to (insert date) test regults radiology studies, films,			
Entire Medical Record, including patient histories, office	to (insert date)			
Entire Medical Record, including patient histories, office referrals, consults, billing records, insurance records, a	Illi Iconias some to y y			
Other:	include. (material by 1			
U VIIIVI.	Alcohol/Drug Treatment			
	Mental Health Information			
	HIV-Related Information			
Authorization to Discuss Health Information				
(b) D By initialing here I authorize	c' 1':1. I hasth own provider			
(b) D By initialing here I authorize Name of individual health care provider				
to discuss my health information with my attorney, or a g	governmental agency, listed here.			
	or Governmental Agency Name) 11. Date or event on which this authorization will expire:			
10. Reason for release of information:	11. Date of event on the same			
At request of individual	At End of it. At. on. 13. Authority to sign on behalf of patient:			
Other:	12 Authority to gign on behalf of patient:			
12. If not the patient, name of person signing form:	15. Authority to sign on bound of passes			
	1 Laddition I have been provided a			
All items on this form have been completed and my questions	about this form have been answered. In addition, I have been provided a			
copy of the form.	$(\sqrt{1/2})$			
copy of the form.	$I \cup I \cup D$			



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

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- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

O. THE ATTORNEY OR	OVERNMENTAL AGENCY SPECIFIED IN TIBILE (C).
CARE WITH ANYONE OTHER THAN THE ATTORNEY OR	ention:
7. Name and address of health provider or entity to release this inform	nation: Ection House Rd, Potana (MD 2085) information will be sent:
Dr CEPAIL S. Goodan, 8001 Insp	ESTION HOUSE KAN CLAMP CHINE
R Name and address of person(s) or category of person to whom this	information will be sent:
LANDMANICORS, BALLAINELFORD	
9(a). Specific information to be released:	(incert date)
9(a). Specific information to be released: [Medical Record from (insert date)	(histori date)
Entire Medical Record, including patient histories, office not	(insert date)
Entire Medical Record, including patient histories, office how referrals, consults, billing records, insurance records, and rec	Oras some to you by a series a
☐ Other:	monuce. (material by minimis)
Li Oute.	Alcohol/Drug Treatment
	Mental Health Information
	HIV-Related Information
Authorization to Discuss Health Information	ALL V - Exclusion Amount
(b) D By initialing here I authorize	Name of individual health care provider
to discuss my health information with my attorney, or a govern	mental agency, listed here:
to discuss my health information with my attorney, or a govern-	
(Attorney/Firm Name or Gove	remental Agency Name)
	11. Date or event on which this authorization will expire:
10. Reason for release of information.	
At request of individual	At End of litigation
O Other:	AT CIA OF AT A STATE OF THE STA
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
·	
14.4 and any quantiana about	this form have been answered. In addition, I have been provided a

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

signature of patient or representative authorized by law.

Date: 11-1-07



UTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
HICELAZAPUS HABER	11-30-33	219-32-9195
Patient Address		
5800 Nicholas LANE, Rock	cville MD 208	352

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL

CARE WITH ANYONE OTHER THAN THE A	TTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).		
7. Name and address of health provider or entity to	release this information:		
Zupnik Winson And	THEN, DDS: 8218 WISCONSIN AVE, BETHE SDAMD 2		
LANDMAN. CORS: BALLAIDE &	Ford: 120 Broadway, 27th FL. NY, NY 10271		
9(a). Specific information to be released:			
☐ Medical Record from (insert date)			
	stories, office notes (except psychotherapy notes), test results, radiology studies, films,		
referrals, consults, billing records, insurance	e records, and records sent to you by other health care providers.		
Other:	Include: (Indicate by Initialing)		
	Alcohol/Drug Treatment		
	Mental Health Information		
Authorization to Discuss Health Information	HIV-Related Information		
(b) ☐ By initialing hereI authoriz	e		
Initials	Initials Name of individual health care provider		
to discuss my health information with my atto	orney, or a governmental agency, listed here:		
(Attorney/F	Firm Name or Governmental Agency Name)		
10. Reason for release of information:	11. Date or event on which this authorization will expire:		
At request of individual			
□ Other:	At End of litigation		
12. If not the patient, name of person signing form			
,			
All items on this form have been completed and my	questions about this form have been answered. In addition, I have been provided a		

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

	Date of Birth	Social Security Number
Patient Name	11-30-53	219-32-9195
Alice LAZArus HABER	1/1-30 3 3	
Patient Address	Pockville, MD2	0852
5800 Nicholas LAME, 1	() CAVIII C 1 Contract to reli	eaced as set forth on this form:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

redisclosure may no longer be protected by federal of state law.	GG MV HEALTH INFORMATION OR MEDICAL
redisclosure may no longer be protected by federal of state law. 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCU	AVAITAL ACENCY SPECIFIED IN ITEM 9 (b).
THE ALLOWING OFFICE THAN THE ALLOWING ON GOTTON	*****
7. Name and address of health provider or entity to release this information: BEHESDA-CHEVY ChASE Ortho: 1021. 8. Name and address of person(s) or category of person to whom this information LANDMAN, CORSI, BAIRME & Ford: 120 B. 9(a) Specific information to be released:	5 FERMOOD RD; BEHNESDAMD 20 81"
156 the 500 or extensive of person to whom this information	will be sent:
8. Name and address of person(s) of calcgory of person as E. 120 R	DWAY, 27"FL. NV. NY 1021
LANDMAN, CORSI, BAINTING LIGID, 120 P	
9(a). Specific information to be released:	4
Medical Record from (insert date)	sychotherapy notes), test results, radiology studies, films,
9(a). Specific information to be released: O Medical Record from (insert date) Entire Medical Record, including patient histories, office notes (except particular medical record, including patient histories, office notes (except particular medical records sent to	you by other health care providers.
Entire Medical Record, including patient histories, office notes (except parent histories), office notes (except parent histor	Include: (Indicate by Initialing)
Other:	menac. (material of times)
	Alcohol/Drug Treatment
	Mental Health Information
THE TAX Provedon	HIV-Related Information
Authorization to Discuss Health Information	
(b) D By initialing here I authorize Name	n: t' * L. I. L. All com provider
Initials	of individual hearth care province
to discuss my health information with my attorney, or a governmental age	ncy, listed here:
(Attorney/Firm Name or Governmental Ag	ency Name)
	or event on which this authorization will expire:
At request of individual	nd of litigation
Other:	NA OT LITTERINGI
12. If not the patient, name of person signing form:	prity to sign on behalf of patient:
14.1 -d and questions about this form	ave been answered. In addition, I have been provided a
All items on this form have been completed and my questions about this form	1 1
copy of the form. \ \ \	
Date:	11111 Ot
All items on this form have been completed and my questions about this form to copy of the form. Date:	111.1.2



UTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

Patient Name ALICE / AZARUS HABET	Date of Birth 11-30-33	Social Security Number 219-32-9195
Patient Address	ck ville, MD 2	20852
	garding my care and treatment be re	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996

- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL

6. THIS AUTHORIZATION DOES NOT AUTHORIZED OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).				
CARE WITH ANYONE OTHER THAN THE ATTORNEY	OR GOVERNMENT TO THE			
7. Name and address of health provider or entity to release this i	miormanon:			
A IVENTIST HOME HEALTH; 120	information: OHI BOURNEFIELD WAY, B, SILVER Spring, MD 2 on this information will be sent: OND; 120 B. DWAY, 22th, FL. NY, NY 10271 to (insert date)			
R Name and address of person(s) or category of person to whom	this information will be sent:			
1 A. COMAL CORS. ROLLAINE & IN	Orp. 120 B. DWAY 12 + Fr. NINI VE			
2(2) Consider information to be released:	*			
(a). Specific information to be released.	to (insert date)			
Medical Record including patient histories, offic	to (insert date)			
referrals, consults, billing records, insurance records, an	nd records sent to you by other health care providers.			
1	Include: (Indicate by Initialing)			
Other:	Alcohol/Drug Treatment			
	Mental Health Information			
	HIV-Related Information			
Authorization to Discuss Health Information				
(b) ☐ By initialing here I authorize	N 6 is dividual health care provider			
Initials	Name of mulvious hearth care provider			
to discuss my health information with my attorney, or a g	overnmental agency, listed here.			
	r Governmental Agency Name) 11. Date or event on which this authorization will expire:			
10. Reason for release of information:				
At request of individual	18 months from signing			
Π Other:	A Month of the State of the Sta			
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:			
Attition this form have been completed and my questions	about this form have been answered. In addition, I have been provided a			
All items on this form have been completed and my questions				
copy of the form.	. / /			



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

ZV 5 m 5	THE TOTAL AND THE			
		Date of Birth	Social Security Number	
Patient Name		11.30.33	219-32-9195	
AlicEL	AZARUS HABER	111-20-22		
Patient Address	N: cholasLANE, Ro	Kull - MD 2	0252	
5800	NicholasLANE, NO	CKVIII E, MID	released as set forth on this form:	
		as I do not have	raleaced at CPT TOTTO ON HHS 1ULLE.	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

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U. TALL TO THE PROPERTY OF THE	VERNMENTAL AGENCY STECHTED HTTALES (2)
CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GO	OD:
7. Name and address of health provider or entity to release this information of the second of the se	ma TEGO'S LANE POTEMAC MD 20854
MANOR CARE POTOMAC, 10/19 POTO	remotion will be sent:
8. Name and address of person(s) or category of person to whom this into	20 Rmoduau 27th FL NV. NV1024
/ /\AIT //VIAN . \CIK \ST /\SI /\III /\III \ST	CO DI DUOMU AIR . I STITTI
9(a). Specific information to be released:	nort data)
9(a). Specific information to be released: 1 Medical Record from (insert date) to (insert date)	except psychotherapy notes), test results, radiology studies, films,
referrals, consults, billing records, insurance records, and record	Include: (Indicate by Initialing)
Other:	Alcohol/Drug Treatment
	Mental Health Information
and dripping and another than the state of t	
Authorization to Discuss Health Information	HIV-Related Information
Authorization to process and	
(b) D By initialing here I authorize	Name of individual health care provider
to discuss my health information with my attorney, or a governme	ental agency, listed here:
1	
(Attorney/Firm Name or Government)	nental Agency Name)
10. Reason for release of information:	. Date or event on which this authorization will expire:
10. Reason for release of information.	
At request of individual	tend of litigation
12. If not the patient, name of person signing form:	. Authority to sign on behalf of patient:
All items on this form have been completed and my questions about thi	s form have been answered. In addition, I have been provided a
All items on this form have been completed and my questions about the	1 ,
copy of the form.	
Colin Harry Halle	Date: /// O +



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

	Date of Birth	Social Security Number
Patient Name	11-30-33	219-32-9195
CNICE LAZARUS HABER	111-20-33	21132 1113
Patient Address 5800 Nicholas LANE, Rocl	Vulle MD 2	2085>
5800 NICHOLAS LANE, RUCI	CVIII C//VII	for the form:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996
(HIPAA), I understand that:

- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

6. THIS AUTHORIZATION DOES NOT THE ATTORNEY	OR COVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).	
6. THIS AUTHORIZATION BOLD TO THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b). CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).		
7. Name and address of health provider or entity to release this information: Shintvincents: 153 West 11th St., NV, NV10011 8. Name and address of person(s) or category of person to whom this information will be sent: 8. Name and address of person(s) or category of person to whom this information will be sent:		
Sointlingents: 153 WEST	1111 31-1 V 11/1 V 1 V OI	
8 Name and address of person(s) or category of person to whom	this information will be sent:	
LANDMAN CORSI RAMAINEL ES	this information will be sent: or 0, 120 BROADWAY, 27th FLNY, NY 1027/	
9(a). Specific information to be released:	<i>*</i>	
9(a). Specific information to be released. ☐ Medical Record from (insert date)	to (insert date)	
Medical Record from (insert date)	_ to (insert date) to (insert date) to (insert date) to (except psychotherapy notes), test results, radiology studies, films, directords sent to you by other health care providers M2#13240	
Entire Medical Record, including parions insurance records and	d records sent to you by other health care providers. ME#1324702	
referrals, consults, bitting records, insurance records,	Include: (Indicate by Initialing)	
🗆 Other:	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information	HIV-Related Information	
(b) D By initialing here I authorize Initials	N. Sindividual health care provider	
Initials	Name of individual feature one provider	
to discuss my health information with my attorney, or a go	vernmental agency, listed flere.	
	Governmental Agency Name) 11. Date or event on which this authorization will expire:	
10. Reason for release of information:		
At request of individual	At End of litigation	
D Other:	Intella Of the Herbott	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
4: 6 have been completed and my questions a	bout this form have been answered. In addition, I have been provided a	
All items on this form have been completed and my questions at		
copy of the form.	1110	
ali dans ustales	Date: 1 0 7	
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UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF NEW YORK	
	07 CV 7060
ALICE LAZARUS HABER,	X
Plaintiff,	
- against -	
NATIONAL RAILROAD PASSENGER CORPORATION d/b/a AM METROPOLITAN TRANSPORTATION AUTHORITY, LONG ISI COMPANY and ABM INDUSTRIES INC.,	*
Defendant.	
	X
PLAINTIFF'S RESPONSE TO DEFENDANT'S FIRS FOR PRODUCTION OF DOCUMENTS	•

LEAV & STEINBERG, LLP Attorneys for Plaintiff 120 Broadway, 18th Floor New York, NY 10271 (212) 766-5222